KDHE Ebola Call
Moderator: Mindee Reece
November 6, 2014
10:00 a.m. CT

Operator: Good morning. My name is (Christy) and I will be your conference operator today. At this time, I would like to welcome everyone to the Ebola Update. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

I will now turn the call over to Ms. Mindee Reece.

Mindee Reece: Good morning, everyone. Thanks for joining us again this week to talk about Ebola. Today, we have a few topics we're going to cover. Charlie Hunt, our state epidemiologist, is going to provide a brief situation update, and Myron Gunsalus, our laboratory director, is going to talk to us about some laboratory issues, then we'll turn it over to Bill Bider, our Bureau of Waste Management director, who is going to talk about biohazardous waste storage. Then I'll take it back and we're going to discuss Ebola exercising at the state, regional, and local levels, and then we'll open it up for questions and answers.

So now, we'll turn it over to Charlie Hunt.

Charlie Hunt: Thank you, Mindee, and good morning, everyone. I will start with a brief situational update for case counts first of all in West Africa – I won't go to each country individually, but in total, with Guinea, Liberia, and Sierra Leone, as of November 2, 2014, there have been 13,015 cases and 4,808 deaths. There have been no changes to the other countries that have had travel-associated cases or those countries with limited transmission.

I do want to make one remark about the Democratic Republic of Congo because we are still considering that a country at risk for our plan. There have been no changes in the number of cases since the last time we talked. There

are 66 cases and 49 deaths. There have been 24 days passed since the last case of Ebola on October 29. After 42 days have passed from the last case, the Democratic Republic of Congo will be considered Ebola free. We'll be watching for that and we'll make adjustments to our guidance accordingly.

Since the last time we've talked, CDC has issued several new guidance and resource documents, and I'll just make brief mention of those here. They have issued resources for parents, schools, and pediatric healthcare professionals on November 4. They have released interim guidance for the U.S. residents' decontamination for Ebola virus disease and removal of contaminated waste that was also issued on November 4. There is an information document for travelers released on November 3.

And then finally, on November 1, CDC released guidance for ambulatory care evaluation of patients with a possible Ebola virus disease. And as with all these guidance materials, we reviewed the guidance and compared that with our plan and determined if any changes are feasible or advisable to the Kansas plan. We will institute those changes and let you all know about those when we release our updated plan.

We learned yesterday that the Obama administration has submitted an emergency funding request for Ebola. This request totaled nearly $6.2 billion; $4.64 billion was for immediate response activities and $1.54 billion was to set up a contingency fund to deal with any additional needs down the road.

Of this total, $1.83 billion would be for the CDC and part of that would be used to assist health departments in several ways to fortify domestic public health systems and to advance the U.S. preparedness with support for more than 50 Ebola treatment centers throughout the country. These funds will help improve Ebola readiness within the state and local public health departments and laboratories, procure personal protective equipment for the Strategic National Stockpile, and increase support for monitoring of travelers.

So again, this is a request by the Obama administration. We will continue to monitor this and certainly keep you all informed about additional resources that might be coming our way and also in terms of supporting your activities.

Last Friday, we did release an updated version of the KDHE Ebola Virus Preparedness and Response Plan. This is version 3.0. The primary difference is in that release where we did change some terminologies of guidance. Previously, we use the terms "optimal" and "minimal" in referencing PPE. We've changed those to "Tier 1" and "Tier 2" in response to some concerns that were raised about the original terms used. So we're happy to do that.

We also updated our guidance on handling the (human) remains of patients infected with Ebola Virus Disease. We've essentially adapted the CDC guidelines. There were some discussions on the call last week about this.

At this time, we don't anticipate any changes to our plan this week. From this point forward, we will do our best to issue any changes on Wednesday ahead of our calls on Thursday with you all.

And then finally, I'll just mention a few things about our active monitoring protocol. Again, this is for travelers that are returning from one of the Ebola-affected regions and have gone through the screening process at one of the five U.S. airports or if they're identified in some other ways as having been in one of the Ebola affected regions. CDC has released additional details regarding implementation and management of the state and local health department active monitoring activities. And in particular, CDC has requested KDHE to provide reports to them.

For those persons that are under what CDC calls active monitoring, we are asked to submit a weekly report to summarize the activities. And then for persons who were under direct active monitoring, again, for CDC this is defined as active monitoring plus the local health department and state health department actually meeting face-to-face with the person that's under monitoring and providing daily reports on that. And just to clarify, at this time, KDHE is not recommending direct active monitoring. But if a local health department chooses to do that, we would work with you and get the information and work with the CDC as they have requested.

And then finally, we hosted a webinar yesterday on implementation of our active monitoring activities. For those of you on the call that might have

joined that, we discussed the notification protocols, how we will be notified from CDC, how we will in turn notify the local health department staff, and finally, how do you use EpiTrax to document the active monitoring activities. If you have any questions about that, please feel free to let us know. With that, I will turn things back over to Mindee.

Mindee Reece: All right. Thanks, Charlie. Next up is the laboratory discussion with Myron Gunsalus.

Myron Gunsalus: Good morning, everyone. This is Myron Gunsalus. A lot of the discussions and questions recently have been about how to handle laboratory testing related to either a suspect, a (highly) suspect, or an actual confirmed Ebola patient. First of all, for diagnostic work for patient care and patient management, both the physicians and the laboratory need to work together to do minimal testing until a patient has actually been ruled out. If you got a highly suspect patient, you need to perform just the testing that's necessary, not a wide variety of diagnostic tests especially if you don't know whether they're confirmed positive yet.

Dedicated point-of-care testing devices are the preferred method of testing. They are available for the basic type of parameters that will be needed for a patient with this type of situation. The one that is not available as far as we can tell yet is something to do with the cross matching, but this may be if you're in a situation where you're managing a confirmed Ebola patient in need of blood transfusion you might have to do something on an emergency basis.

The overall recommendation is not to take a patient specimen to your main hospital laboratory for testing. There are several reasons for this. The ASM Guidance recommends against this, but it's also because many of the common analyzers that would be used in the main laboratory. They use vacuum systems. They have various waste protocols and some of them require manipulation of the specimen itself, all of which exposes your laboratory to the potential for contamination of the laboratory as well as the workers. So it's recommended not to do that.

If you're using point-of-care devices, ideally use those utilize a cartridge of some sort that are self contained. I know many of our hospitals in the state use i-STATs, which are kind of a cartridge-based chem panel with the metabolics in it. Those are good – anything that does not require additional manipulation, avoiding centrifugation if you can, especially if it's open, avoiding vacuum systems and things like that could cause aerasolization or droplet splatter. And if you do test in any of your equipment, talk to manufacturers about decontamination but, again, you're looking at a dedicated point-of-care situation ideally adjacent to the patient room or in the patient room.

The other question that came up last week was regarding some of the newer testing protocols, the new testing platforms that are coming out that are being made available to test for Ebola virus, such as the BioFire platform and there are others that are still on the way out.

The BioFire, for instance, has been given an FDA emergency use authorization, but that does not forego the requirement for hospitals to still required to contact the state health department. It does not get you out of having the sample tested by a Laboratory Response Network (LRN) laboratory as well as CDC. The only confirmatory testing for Ebola is done at CDC. And so it may or may not actually save any time and it may give a false sense of security or a false sense of concern. There are also some concerns about the sensitivity of the BioFire.

The other thing to keep in mind is if you have a patient who presents fairly early with symptoms and they're highly suspected of having Ebola, and then you get a negative result from the BioFire test. The patient should still be considered suspected of having Ebola and will not be cleared for the next laboratory test for 72 hours. So when you consider using some sort of testing for Ebola virus, there's quite a bit of consideration that needs to be taken into account in terms of what does it really tell you, what is your real goal in having some additional testing besides what CDC or your LRN laboratories can do. The one thing that the FDA plans is states that the BioFire testing is not to be used for patient management decisions. With that, back to you.

Mindee Reece: OK. Thank you, Myron. Now, we'll hear from Bill Bider, the Bureau of Waste Management director, with some information on biohazardous waste storage.

Bill Bider: OK. Good morning. What I'm going to talk about this morning is more of a focused look at some of the waste issues. I'm not going to talk about everything but I would be happy to answer questions later. My comments today will primarily cover some questions that relate to the packaging and then storage of any Ebola waste from a suspected or confirmed patient that could be generated.

We, yesterday, prepared another document which I believe will become available online very soon. It's going to be titled, "Biohazardous Ebola Waste Storage for Generating Medical Facilities." I'm going to just cover some of the highlights of this document, which you'll be able to check. There are some other things that you may want to look at that are available online.

And probably, most importantly, it would be a national permit issued by the U.S. Department of Transportation, and it has a permit number that I will tell you. But we have a link in the document that's going to be provided online to take you to this permit because it becomes very important to determine the types of packaging that should be used, and that is Special Permit 16279, and that is available online, and it does have all of the detailed packaging that is being specified to ship Ebola waste, both inner packaging and outer packaging.

And just for today, I'd like to just say that within the area where patient care is given is where the initial packaging should all be completed before waste material is moved to a secured storage area. The inner packaging has a minimum of two of these plastic bags, one inside the other with some disinfection or treatment of those bags before they're put into a container. Now, the DOT permit provides a lot of the details about the type of bags and how they should be utilized.

But then the bags themselves need to be put inside of a container. There are different alternatives, but the one that we recommend is a corrugated

fiberboard 55-gallon drum. The bags should be put into the drum and they would then be labeled and taken to a secure storage area.

Now, the reason that we are presently recommending those drums even for suspect material is because if it turns out that Ebola is not confirmed but some waste is generated early in the process, those drums would be suitable then to be managed just as regulated medical waste, which all of you are used to managing and disposing of.

If it turns out that Ebola is confirmed, those 55-gallon drums will be placed in larger 95-gallon Overpack plastic polyethylene drums with a big screw-on lid. Usually, they're yellow. The only facility in this country right now taking Ebola waste is a facility called Veolia in Port Arthur, Texas, and that is the only kind of container that they will receive, but that could change.

So the initial storage at any generating facility, whether it's confirmed or still suspect, should be in this 55-gallon containers that are very much specified in the DOT permit, which needs to be complied with in order for Ebola waste to be legally shipped across stateliness. So you will have inner packaging, plastic bags, placed inside the first level of outer packaging, which is the corrugated fiberboard 55-gallon drum. Then we have another outer packaging to make the waste suitable for shipping to the only currently receiving facility in the U.S.

Now, it's possible that other facilities will arise and it will satisfy DOT to leave the Ebola waste only in the 55-gallon fiberboard drum if these other facilities get approved as a potential disposal option. The one thing that I want to mention to everyone is as soon as you would have any possibility of generating Ebola waste we would just strongly recommend that you contact KDHE and let us work with you right from day one to make sure that everything is clearly understood.

Another thing is these drums do need to have some labeling on them when they go into the storage. We're saying it needs to be moved then out of the patient area into a secured storage area. The outside of the 55-gallon fiber

drum needs to be decontaminated in accordance with the instructions that are on the permit before being moved into that secured storage area.

The storage area within the medical facility can be any kind of room; it just needs to be lockable. There should be a sign placed on the doorway and every drum needs a label. It needs a label that says "Infectious Waste" and that shows it is a hazardous waste because in Kansas we're calling this hazardous. And then it has to be dated because you can only keep it for 90 days in the storage area.

So for now, I think that's all. I'll be happy to answer questions of other things that relate to waste issues that I did not cover in that presentation.

Mindee Reece: OK. Thanks, Bill. Now, I'm going to talk a little bit about exercising. As all of you I'm sure are aware exercising is a big part of preparedness. The state has taken that to heart and in collaboration with the Governor's Office and various other state level departments including the Division of Emergency Management, Highway Patrol, and others, we conducted an Executive Leadership Seminar about Ebola on October 28.

During that discussion, we focused on the policy-related information that we would all need to be cognizant of and practice in order to make sure our government was ready to respond from the policy level. In follow-up to that event, we are planning a state government tabletop exercise on November 28 where we will be discussing and reviewing our operational plans. That is very important in our overall readiness for a potential case of Ebola in our state.

So those are the things that are going on. I also want to talk about community-level exercising. We are hearing in our recent federal calls a big push for us to encourage hospitals, local health departments, and other community partners to exercise their plans for dealing with a potential Ebola case in Kansas.

Lisa Williams, who is our exercise coordinator, distributed via the Kansas Health Alert Network in the recent past a tabletop exercise template that's designed to help communities prepare and discuss their response to Ebola. We know at this point that two of the healthcare coalitions are using this

exercise to meet the regional preparedness exercise requirements. Those are the Northwest Kansas Healthcare Coalition and the Southeast Kansas Healthcare Coalition.

We are aware that not all of the healthcare coalitions are hosting this exercise because some have already hosted a regional exercise and others have set their alternative plans for that conducting a regional exercise. With that said, we do encourage hospitals and local health departments to gather with their community partners to conduct this tabletop exercise. It will really focus on health and medical systems operation. However, the whole community understanding of the issues related to the Ebola response is valuable and beneficial.

If you haven't made any plans to do a drill within your facility or a community-based tabletop exercise, please consider doing so. We are here to assist you. Please feel free to contact Lisa Williams. Her phone number is 785-296-1984 and her e-mail address is lawilliams@kdheks.gov. You can also contact KDHE at the response2014@kdheks.gov e-mail address to request assistance or information about exercising.

I want to give just a couple of reminders before we move into questions and answers. First of all, last week, we announced that we are going to be holding regional Ebola discussions at seven Regional Healthcare Coalition meetings that are scheduled in November and December. As of today, we have 47 registered in Olathe, 53 in Wichita, 44 in Topeka, 48 in Salina, 61 in Hays, 44 in Chanute, and 49 in Garden City.

I want to remind you that the registration for this meeting is on KS-TRAIN. The course ID number is 1053984. We have confirmed that at each meeting Dr. Moser, Aaron Dunkel, Charlie Hunt, Myron Gunsalus, and I will be present, and someone from our Division of Environment, either John Mitchell, the director of the Division of Environment, Mike Tate, who is the Bureau of Water director, or Bill Bider, the Bureau of Waste Management director will be at each of the meetings, as well.

It will be a great opportunity for all of you to have face-to-face interaction with the subject matter experts that might have answers to your questions or can at least help address some of the concerns you might be having related to planning for and caring for a potential Ebola patient.

Another thing I want to announce is that we will be having a call next Thursday at 10 a.m. to carry on the conversations about Ebola preparedness. To join the call, the participant call-in number is 877-388-6280. The conference ID or passcode that you'll need to enter is 32753411. We will send this information out via the Kansas Health Alert Network and other means and it will also be posted on the KDHE Website, but I wanted to give you a heads up to plan to participate in next week's call.

Now, at this time, we will open it for questions.

Operator: At this time, I would like to remind everyone in order to ask a question, simply press star then the number one on your telephone keypad. Again, that's star then the number one to ask a question.

Your first question comes from the line of Susan Cooper.

Susan Cooper: (Inaudible). How come I'm the first one? Anyhow, when you are coming out to the Healthcare Coalition meetings, are you going to be addressing or somebody is going to have the knowledge for patient transfers? Is there going to be some representation from EMS?

Mindee Reece: We've invited EMS to participate, but it's actually a good recommendation. We can invite someone from MERGe, which is our agreed upon patient transport entity for any case in Kansas that we need to move from one facility to another or at Kansas facility to Nebraska. So we'll invite representative from MERGe to join us for those meetings. Good suggestion.

Susan Cooper: Anytime, Mindee.

Mindee Reece: OK.

Operator: Your next question comes from the line of (Carrie Jonda).

(Joann Harris): This is (Joann Harris) and I have a series of questions that's been raised by our physician group. The first is that everyone has got a certain amount of PPE in their hospitals but usually for us it is right now a two-day supply. We've got a backorder, of course, for more. And the question was raised, is there a stockpile of PPE in Kansas? Where is it? And if we do get a case of Ebola and KDHE comes to the hospital right away with a BioStrike Team, will you be bringing PPE supplies with you?

Mindee Reece: That's a good question. We do have a small stockpile of personal protective equipment we purchased with federal preparedness funds that we have inventoried and we know that it's available. What we haven't done is to do a crosswalk with the various PPE that each facility would need because I know there are differences in the makes and models of PPE used across the state's health and medical system. If you have specific questions about your cache and want to compare it to what we have at the state, please send that information with the details to the response2014 e-mail address and we can get back to you with specific conversation related to that.

(Joann Harris): The physicians and the immediate in-room caregivers want to know that if after 48 hours they're going to have continued supply of PPE.

Charlie Hunt: Hi, Dr. Harris, this is Charlie.

(Joann Harris): Hi, Charlie.

Charlie Hunt: Hi, we haven't been given specifics about this. We understand CDC is also developing some stock of PPE available that would be potentially sent to states to assist the hospitals as cases occur.

Mindee Reece: I just asked this morning for Preparedness staff to check into that to see what specific availability of person protective equipment and durable medical goods we could access through the Strategic National Stockpile.

Yesterday on a national call, the CDC indicated that as long as it wasn't a very rural and remote area, they could have PPE supplies in the hands of the state

within a three-hour time period of request, which is very quick, compared to what we've been told in the past.

So we're in the process of doing some fact finding to get more details, which we will share with all of you.

(Joann Harris): This is great because that's a big issue on our provider's part. One of the questions that we keep running around which is in the KDHE response plan is – I just want to clarify, if we have a doctor on a 24-hour shift in the room wearing PPE, no breaches, they will only be taking care of that patient. Once they're off their shift, will they then be able to take care of other patients? You know like they go off and their 24 hours is done and they go back to their regular patient care role, what is the stand on that?

Charlie Hunt: This is Charlie and again, if they're utilizing the Tier 1 PPE we would not recommend additional restrictions in terms of other patient care.

(Joann Harris): I think you mean Tier 2?

Charlie Hunt: No, I mean Tier 1.

(Joann Harris): Well, which is the highest?

Charlie Hunt: Tier 1 is the highest.

(Joann Harris): OK, we didn't get that before. OK, so if they're using Tier 1 and they've had no breaches then they will do self monitoring for 21 days but they can go about their practice after that?

Charlie Hunt: Yes, just a minor correction. It would be active monitoring so they would still be receiving daily follow-up by the local health department or KDHE.

(Joann Harris): Yes, so they have to report in everyday?

Charlie Hunt: Correct.

(Joann Harris): But they can take care of patients, because that was a big question on the doc's part.

Charlie Hunt: Yes.

(Joann Harris): Then the third question is related to the lab and so we are understanding and we do have i-Stat and we're point of care, etc. but the question on a suspect patient, is that we don't want patients to die of typhoid or malaria while we're waiting to find out if they have Ebola and does the state have any guidance on how to test for malaria and typhoid on a suspect patient who may not have Ebola in the end? Those are just two examples of the more common diseases.

Myron Gunsalus: We would have to deal with that on a case-by-case basis. If there was a discussion of that and if the patient was highly suspected of having Ebola, we would have to figure out if there was some other alternative place, maybe some more classical ways for additional testing. The main thing is to keep the handling of specimens from this patient to a minimum in the laboratory.

(Joann Harris): We understand that but from other places that I've discussed that with, Ebola very much can look like malaria. I know malaria; I don't know Ebola – thank goodness. They can very much look alike and it's one of the first things the infectious disease societies are recommending you rule out.

Myron Gunsalus: I agree. Again, you just have to look at the overall guidance for how to, with the technology that you're using, rule out the malaria and make sure that it is done in such a way to minimize exposure to both lab staff and equipment.

(Joann Harris): And again those two tests would not be point of care. There is a point of care malaria actually but that would have to go to the main lab so just FYI you know. Directed care, one of the questions that we had.

We have pediatric population here in Topeka you know NICU, Ob-Gyn, special populations, and there is a concern about the issue of regionalization. Where is Kansas standing on regionalization, picking designated facilities for Ebola care and therefore how to transfer to them?

Mindee Reece: This is Mindee again. I just spoke with Dr. Moser about this, this morning. We are not currently planning on having a designated Ebola hospital or Ebola hospitals in our state. We're asking that every hospital be capable of isolating

and caring for a suspected or confirmed Ebola patient for up to 48 hours. We are still investigating and hoping for the ability to transfer any patients we have in Kansas to the Nebraska bio-containment unit.

So at this time, we're querying the large hospitals to ask about their readiness but were not pushing anyone to identify as a regional or a state-level Ebola hospital.

(Joann Harris) e: Right. So my question is this, Nebraska has two beds.

Mindee Reece: Nebraska's biocontainment unit has 10 beds.

(Joann Harris): No. Currently they're using two.

Mindee Reece: Currently, they're using two but they have 10 beds available, so they have eight beds available at the time.

(Joann Harris): OK, so that's a big physician question. Again 48 hours getting the patient stabilized, ruling in and out Ebola. and I just heard you say that again if you have a patient that's early it would be 72 hours to repeat the test so all hospitals in the State of Kansas will have to be capable of taking care of a patient for 72 hours, that's what I'm hearing you say.

Mindee Reece: Well, I think what we have said today is that we want every hospital in the state to be able to isolate for up to 48 hours and then each hospital needs to be talk with their typical referral hospital. If you're a community hospital in Northwest Kansas and Hays Regional Medical Center is your traditional referral hospital, we would ask those community hospitals to communicate ahead of time with Hays Regional Medical Center to find out if they would be willing to accept an Ebola patient. If the referral processes aren't going to work like they typically do then those hospitals would need to have specific conversation with KDHE to discuss other options. Charlie, do you want to elaborate on that?

Charlie Hunt: That's right and given that the initial assessment and isolation of patient is also consistent with what the message with CDC has been giving; every

hospital needs to be prepared to at least have a patient show up with Ebola symptoms for assessment and subsequent isolation.

(Joann Harris): Yes, and that's not what we're asking. We know about the patient that's going to show up at the door and that we are certainly capable in Topeka, Kansas at Stormont to handle that. The question becomes after 48 to 72 hours?

Charlie Hunt: As Mindee indicated we are continuing discussions with the hospitals here in this state and again our plan would be to at least request the Nebraska Medical Center to accept the patient and get approvals from them.

(Joann Harris): OK. Thank you so much for taking the time to answer these questions.

Operator: Your next question comes from the line of Steve Hoeger.

Steve Hagger: Good morning, Charlie, good morning Mindee.

Mindee Reece: Good morning.

Steve Hagger: We have two questions. Number one, I'll ask, and you guys have done a great job with the response 2014, but have you thought about a frequently asked questions site so you don't have to answer the same questions over and over which might be helpful to see what other people are asking and getting guidance from you.

So that's question number one.

(Sarah Belfry): This is (Sarah Belfry); I'm the Communications Director here at KDHE. We actually have two frequently asked question sheets on our Ebola home page. One is specifically geared towards healthcare workers and one is just for the general public.

The healthcare worker's frequently asked question sheet is being updated on a regular basis based on the questions that we have been receiving from facilities and the questions that we've been seeing through either the response2014 e-mail address or the weekly conference calls. That was just

updated last week and we will be looking again today and tomorrow at adding any additional questions that we've been getting.

Steve Hoeger: Thanks, (Sarah) and our second question…

(Robert Hun): Hi, this is (Robert Hun). I had a question regarding waste management. There is a reference to disinfecting the bags prior to putting them into the containers. Is that disinfection we're talking about the outside of the bag or inside of the bag, and the risks and benefits of that process?

Charlie Hunt: Well, the procedures are defined pretty well in the DOT permit which I would refer you to, we at KDHE's Bureau of Waste Management did not further try to refine that. I don't know whether any of you did but we're just going with the recommended guidelines that DOT established so I really would refer you to that for that permit which you can download and look at.

There is one other aspect that I didn't mention regarding when the bags are placed in the drum. There should be some absorbent material placed in the bottom of the drum and that's also specified in the permit. So all that information is available there in more detail and we're deferring to that expertise and guidance rather than us trying to reevaluate that and provide some additional information.

(Robert Hun): OK, thank you.

Operator: Your next question comes from the line of (Chad Holmes). Hello, (Chad) are you there? Do we have a Girard Medical Center?

Female: Yes. My question is, and I hate to keep bringing this up but I really have to – I know you guys are doing what you can do and you're trying to do a good job and I understand allocation of PPE, but I just want to ask a question, are you guys aware that you are telling hospitals to be ready for 72 hours?

I have contacted some of my infection control co-workers around the state and basically what I'm hearing back from them is that many of the supplies that hospitals ordered have not always been kept updated and many of the suits when they check on them are expired.

I'm even hearing that some of the local caches that are in storage are either expired or ready to expire. So basically, I guess I need an answer. I'm standing here feeling like what we're being asked to do is almost impossible when we don't have some of the PPE that we need, particularly the suits. I think if we can't order them and we can't get them, I don't see how we can care for these patients. So could you give me some feedback on that?

Mindee Reece: What we are asking hospitals and local health departments to do is to look through their own cache of personal protective equipment to determine what you have and what you need.

Check with your community partners – if you can't get anymore from them, check with your regional hospital coordinator. If they don't have what you need then you can go ahead and put forward a request through your local emergency manager to the state for the PPE that you would need for that first 48 to 72 hours to isolate and care for a patient.

So if you have specific things that you feel you just cannot get, go ahead and work with your local emergency manager to make the request to the state. We're not planning on supplying every hospital for the PPE they need for weeks of caring for a patient. But for that first 48 to 72 hours, we will work with our sources to get you what you need.

Operator: At this time, you do have a followup question from Susan Cooper.

Susan Cooper: I'm sorry I just can't keep my mouth closed. I have three followups, first is on the training. I'm getting requests from critical access hospitals to come out and help their staff with infectious PPE donning and doffing and I had talked with Michael McNulty earlier this week, there's some excellent videos out that CDC and Johns Hopkins have put out. Emory has a good procedure guide. I'm very hesitant to suggest anything because I don't want to train on something then have the state say this is how we're going to do it and then have to untrain. So where are we at with the training?

Charlie Hunt: This is Charlie and we are working on the training. I anticipate that we will have some training available within the next few days and we'll certainly push that out as soon as we have completed it.

Susan Cooper: OK, the second question that I have and this is after listening to Dr. Nicole Lurie last Friday on HHS conference call. She sort of indicated that not everybody has to be in Optimal or Tier 1 PPE from the moment that a patient presents, that it really is a matter of what their symptoms are. Did I misunderstand that?

Charlie Hunt: No, this is Charlie and again, I think it is appropriate to consider that PPE should reflect the type of care that is anticipated. So for example, we have specific guidelines for outpatient settings and if a patient is presenting and has at that point just mild symptoms, it is very early stages of their illness and that is a consideration.

Again, our guidance is to minimize patient contact. Try to maintain a separation distance of three feet and really limit the hands-on direct patient care, if possible. The same thing would be true in an emergency department setting so long as the patient is not exhibiting vomiting, diarrhea, or bleeding. The direct contact patient care can be minimized; the patient can be transported and isolated appropriately.

So again, the goal here is to minimize the potential exposure. I understand the concerns about our recommendations. Other than the specific guidance for outpatient settings we've not identified PPE for different levels of care.

Again, we would have to consider what kind of care was being provided and what the potential exposures were. If there is only minimal contact or no direct contact and a provider was not wearing the Tier 1 PPE that certainly can be taken into consideration in terms of our recommendations for any restricted movement. Does that help?

Susan Cooper: Well sort of. So if somebody comes in and says they've come back from Africa, and this actually this happened in the Northwest area, somebody from a rural area had just come back from Africa after hunting and while he was returning to the U.S. his plane stopped in a country with widespread Ebola.

They took on passengers from that country and when this traveler got back to Kansas he had a low grade temperature. He was aching and went to the hospital.

I guess my third question is has there been any kind of study about the viral shift? My understanding is while they're potentially infectious when they are just aching and having a headache or low grade temperature it is not until they start producing volumes of body fluid that the virus has dosed up enough in the body to actually cause infection to another person. Am I way off base here? I'm not an infection preventionist.

Charlie Hunt: Yes, that's correct. Again, it's by direct contact. It is how it is transmitted, so clearly if there are more body fluids present then the risk of transmission would be higher and as a person goes further into the course of illness then the viral load will also increase.

But getting back to your earlier point about the plane that stopped over in Africa, just a layover at an airport would not be the same as a person being in a country per se. Anyone that was getting on that plane, unless they were a patient with active Ebola disease, would not be presenting a risk to anyone else on the plane and so at that point, your initial risk assessment or screening at the hospital would have essentially ruled out potential Ebola.

Susan Cooper: OK, because I think that this would help a lot of hospitals across the state, not just critical access. If you can say you know just because somebody, the fact that they coming in and Dr. Lurie alluded to this last week, if they're coming in and they are not – they've not been in the country per se. They've not had contact with anybody that they know of and if they're presenting these kinds of symptoms then you should say OK, well you don't have Ebola.

But use universal precautions while you're waiting for lab tests to be confirmed, go to Tier 1 after that – I think that is what would really help a lot of hospitals to know specifically what it is they need to do.

Charlie Hunt: We've tried to be very clear about the definition for risk for a person with Ebola. That is having been in or traveled in one of the affected countries and exhibiting symptoms that are consistent with Ebola.

If that first criterion is not met, if they've been in a country that is not one of the affected countries, at that point then we would not be concerned about Ebola.

Susan Cooper: OK.

Charlie Hunt: I think we've provided pretty clear guidance about that. We've provided tools, resources and posters that many of the hospitals have reported in our most recent survey they actually have posted. I think again refer back to our plan and to those resources that we've provided.

Susan Cooper: And just a followup comment, when I've talked with several folks in my region what they're saying is yes they could handle a patient in isolation while they're waiting for some kind of lab work but they do not have the capability to handle someone who is starting to go into higher problems with respiratory distress or multisystem failure or kidney failure, those kinds of things.

They're going to be moving those folks on and I think that there's been maybe a misconception that they're going to have to hold these folks until they've got a positive and they're saying we can't do it because we don't have the capability. Just a clarification, so if you need somebody on a ventilator, you're going to move them to a higher level of care because that's what you normally would do.

Charlie Hunt: We've not intended to imply in any of our guidance that a hospital must hold a patient until a definitive diagnosis of Ebola is made or ruled out. Again, I'll just reiterate that what we've advised is for hospitals to discuss with the hospitals that they would normally refer to and hospitals that they normally get patients referred from about how they're going to manage a potential Ebola patient. If it means that the smaller hospital is not prepared to provide high levels of care during that two to three day period while we're waiting, then those are discussions that you all need to be having in how you're going to arrange for patient transport.

Susan Cooper: OK, thank you.

Operator: Once again, if you would like to ask a question press stars then the number 1 on your telephone keypad. Again, to ask a question, press star then the number one.

You do have a question from Nancy Lucas.

Nancy Lucas: Hi, I was getting conflicting information regarding our isolation rooms themselves, what we have here is an air exchange unit so many times per hour but I've read that they need to be in a negative air room and we don't have that available. Is there any truth in that?

Charlie Hunt: We will take a look at the guidance but right now there is not any specific guidance that the patient needs to be in an airborne infection isolation room, which would involve the negative air pressure and so many exchanges per hour unless aerosol generating procedures are being performed.

Nancy Lucas: OK.

Charlie: So again, if you do not have an airborne infection isolation room and you know you've got a suspected Ebola patient and for some reason they would need to have procedures that would generate aerosol then you probably do need to look at transferring that patient to facility that could handle that more appropriately.

Nancy Lucas: OK, thank you.

Operator: Again if you would like to ask a question, press star, then the number one on your telephone keypad.

Mindee Reece: This is Mindee; if there are no more questions I will just repeat that we are having a conference call again next week on Thursday at 10 a.m. The dial in information is 877-388-6280. The conference ID is 32753411. To register for one of the regional healthcare coalition meetings, the train course ID number is 1053984 and, as always, you can contact us by e-mail at response2014@kdatks.gov or via the EPI hotline which is staffed 24 hours a day, 7 days a week, that number is 877-427-7317. (Christie) are there any more questions?

Operator: We did have a followup from Terry Janda. Hello, Terry Janda?

Terry Janda: Hello?

Mindee Reece: Yes, we can hear you.

Terry Janda: Thank you, has any thought been given to or is there a recommendation for terminal cleaning specific to UV light and/or hydrogen peroxide aerosol?

Charlie: No, we have not given consideration to that.

Terry Janda: OK, thank you.

Mindee Reece: All right, thank you.

Operator: There is one other question. One moment. The question comes from the line of Sandy Stroud.

Sandy Stroud: I have a question about the 21-day isolation. If I have a patient that comes in to my clinic and we're currently screening everybody that comes into any department but if my receptionist screens this patient and this patient does say that they've had travel and she takes them to the designated isolation room does she have to be monitored – I mean since she has had no actual direct contact with that patient, does she have to not be allowed to work with other patients for 21 days or do we just monitor her with her temp?

Charlie Hunt: This is Charlie and again if she's maintained that three-foot distance and didn't have any direct contact with the patient, we would not consider her at risk of exposure.

Sandy Stroud: OK, thank you.

Operator: OK, there are no further questions at this time.

Mindee Reece: All right. I want to again express our appreciation to all of you for joining in the call today and we hope your preparedness planning is continuing as ours is

at the state level. We look forward to speaking with you again, same time next week. Thank you.

Operator: Thank you for participating in today's call, you may now disconnect.

END